CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

SUMMARY OF DISABILITY

THIS FORM MUST BE COMPLETED FOR ALL INITIAL CLAIMS. ALL BENEFIT TIME MUST BE DOCUMENTED FROM DATE OF ACCIDENT THROUGH RETURN TO WORK DATE.

Agency	Date of Accident / Incident	Bargaining Unit
Injured Employee	Date Form Completed	Central File #

Benefits Utilized as a result of the accident / incident	Number of Days	Provide Dates	Amount Paid
Service Connected			
Regular Days Off			
Accumulated Sick Leave			
Compensatory Time			
Holiday Time			
Vacation Time			
Personal Time			
TTD			
Other (Explain)			
(Reinstated)			
TOTAL	0		0

Date Returned to Work _____ (Month, Day, Year) If T.T.D. reinstated, RTW Date _____ T.T.D. Termination Date _____ (If different than RTW date)

Computation of Workers' Compensation Rate

Month / Year thru Month / Year			(Use calculation formula shown below to ensure accuracy.)
	_____ Months at $_____	Equals $	0.00
	_____ Months at $_____	Equals $	0.00
	_____ Months at $_____	Equals $	0.00
If Applicable: Mandatory Overtime Income	_____ Months at $_____	Equals $	0.00

Is this individual a contractual employee? ☐ Yes ☐ No Total Yearly Salary $ 0.00

Average Weekly Salary (Divide Yearly Salary by 52 or, if less than 12 months divide by **actual** # of weeks) $

Weekly T.T.D. Rate (2/3 Weekly Salary) $

Daily T.T.D. Rate (1/7 Weekly T.T.D. Rate) $

P.P.D. Rate (60% of A.W.W.) $